

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12023

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11994

Reg. Dist.

No. 185

1. PLACE OF DEATH: COUNTY <u>Harford Maryland</u> STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Abundeen</u> LENGTH OF STAY (in this place) <u>D.O.A.</u> TOWN <u>Abundeen</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Abundeen</u> TOWN <u>Abundeen</u> STREET ADDRESS (If rural, give location) <u>170 Deen</u>			
3. NAME OF DECEASED: (Type or Print) <u>Casper</u> (First) (Middle) (Last) <u>Ansolvish</u>				4. DATE OF DEATH <u>December 31 19 55</u> (Month) (Day) (Year)			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>8/19/1894</u>	
9. AGE, last birthday: <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Ansolvish</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ann Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>218-14-6693</u>		17. INFORMANT & ADDRESS: <u>John Ansolvish, Harford, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>Crushing injury R chest</u> Immediate cause (a) DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture both lower both legs</u>							
19a. DATE OF OPERATION: <u>12/31/55</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Route 40</u>		21c. (City or town) (County) (State) <u>Abundeen Harford Md</u>		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12/31/55 9 P. M.</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto accident, into auto type</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Lerald C Palmer</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/11/56</u> M. D. ASSISTANT MEDICAL EXAM. <u>8/11/56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Brookview</u>		LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 3-1956</u>		REGISTRAR'S SIGNATURE <u>W. L. Lewis M.D.</u>		24. FUNERAL DIRECTOR <u>Brooklyn Md.</u>		ADDRESS <u>Brooklyn Md.</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12021

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1-1905

No. 180-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Harford</u>				CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Harford</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				STREET ADDRESS <u>170 E. Deen</u> (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Reba MORRISON Ansalvish</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 31 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>		8. DATE OF BIRTH: <u>3/28/1890</u>	
9. AGE last birthday: <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Home Wife</u>		11. BIRTHPLACE (State or foreign country): <u>Rising Sun</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Samuel M. Morrison</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Holden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service): <u>No</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Samuel M. White, Rising Sun, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Fracture skull</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>12/31/55</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH: <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>502-40</u>		21c. (City or town) (County) (State): <u>Harford Harford Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>12/31/55 9 P. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>A rtho accident, auto onto type</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Donald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/1/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Brookview</u>		LOCATION (City, town, or county) (State): <u>Rising Sun, Md.</u>	
DATE REC'D BY LOCAL REG: <u>Jan 3-1956</u>		REGISTRAR'S SIGNATURE: <u>G. L. Lewis M. D.</u>		24. FUNERAL DIRECTOR: <u>Thurman J. Davis</u>		ADDRESS: <u>Harford Md.</u>	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11996

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## CERTIFICATE OF DEATH

Reg. Dist. No. 151

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>West Virginia</i> COUNTY <i>Monroe</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>31 Aberdeen</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Laurel Branch</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00 #320 S. Phila Blvd.</i>				STREET ADDRESS (If rural give location) <i>85x3</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <i>Virginia Katherine Arthur</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>12 12 1955</i>			
<b>5. SEX</b> <i>Female</i>		<b>6. COLOR OR RACE</b> <i>White</i>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Single</i>		<b>8. DATE OF BIRTH</b> <i>Oct 16 - 1861</i>	
<b>9. AGE last birthday</b> <i>- 94 yrs.</i>		<b>10. IF UNDER 1 YEAR</b> Months Days		<b>11. IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Home</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>West Virginia</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>William Arthur</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Jane Helbers.</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>none</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Maggie Campbell Box #289 Aberdeen Md.</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <i>Arterio Sclerosis Cardiovascular</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO</b>							
<b>STATING UNDERLYING CAUSE LAST. (C)</b> <i>Coronary Thrombosis</i>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>April 1, 1955</i>, to <i>Dec 12, 1955</i>, that I last saw the deceased alive on <i>Dec 12 1955</i>, and that death occurred at <i>4:00</i> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Charles J. Foley</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>John W. Simon Md 12/12/55</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Removal</i>		<b>DATE THEREOF</b> <i>12/13/55</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Arthur Cemetery</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Laurel Branch West Virginia</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Hellie R. Perry</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John G. Sarving Aberdeen Md.</i>			
<b>DATE</b> <i>Dec-13-55</i>							

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or write in full)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial society

18. Signature of religious society

19. Signature of family

20. Signature of community

21. Signature of state

22. Signature of nation

23. Signature of world

24. Signature of universe

25. Signature of everything

26. Signature of nothing

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 180-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <i>David de Grace</i>	<i>2.3 mos</i>	TOWN <i>David de Grace</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>667 Otsego St</i>		STREET ADDRESS (If rural, give location) <i>667 Otsego St.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>JAMES EARNEST BANTON</i>		<i>Dec 19 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH: <i>May 2 1892</i>
9. AGE last birthday: <i>63</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Widow Mary Kent</i>	
11. BIRTHPLACE (State or foreign country): <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Unknown</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No.: <i>Unknown</i>	
17. INFORMANT & ADDRESS: <i>900 Hunting Ave</i>		<i>Raymond L Banton, Balto. 25, Md</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		<i>instant</i>	
420.1 Immediate cause (a) <i>Coronary Thrombosis</i> DUE TO			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Carcinoma Stomach with metastasis</i>			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Philip W. Durnan</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>Dec 19, 55</i>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Buried</i>	DATE THEREOF: <i>12/21/55</i>	NAME OF CEMETERY OR CREMATORY: <i>Frankford</i>	LOCATION (City, town, or county) (State): <i>Frankford W. Va</i>
DATE REC'D BY LOCAL REG: <i>Dec 20-1955</i>	REGISTRAR'S SIGNATURE: <i>G. L. Lewis M.D.</i>	24. FUNERAL DIRECTOR: <i>Thompson &amp; Son de Grace, Md.</i> ADDRESS	

MARGIN RESERVED FOR BINDING

WS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 23 1915

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11998

# 12022 CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hickory</u>		<u>84415</u>		TOWN <u>Hickory</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Forest Hill RD</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>PRESTON THEOMAS BARRON</u>				<u>DEC 27 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>JULY 24 1871</u>	<u>84</u> yrs.	<u>5</u> Months <u>3</u> Days	<u>8</u> Hours <u>24</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Farmer</u>		<u>Retired</u>		<u>Chestnut Hill MD</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John H. Barron</u>				<u>Margaret Stump Smith</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>						<u>Edward S. Barron Forest Hill MD</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE</b> (A) <u>Arteriosclerotic CV Disease</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <u></u>							
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> (C) <u></u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (Country) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19..... that I last saw the deceased alive on....., 19....., and that death occurred at.....M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Lerald C Palmer</u>				<u>M.D. Deputy Medical Examiner</u>		<u>12/28/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>DEC 30 1955</u>		<u>Deer Creek</u>		<u>Chestnut Hill MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>12-30-55</u>		<u>Priscilla Townsend</u>		<u>William H. Keith Jr.</u>		<u>Partholville</u>	

12005 CERTIFICATE OF DEATH

Name of Deceased: *Thomas White*  
 Date of Death: *July 24 1911*  
 Age: *24*  
 Sex: *Male*  
 Cause of Death: *Heart*  
 Place of Death: *Home*  
 Signature: *Thomas White*  
 Date: *Dec 17 11*

BUREAU V. 3

JAN 2 1916

RECEIVED

The State of Maryland  
 Department of Health  
 Baltimore, Md.  
 Jan 2 1916

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12000

12023 **CERTIFICATE OF DEATH**

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Rural</b>		LENGTH OF STAY (In this place) <b>9 yrs.,</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen R.D.</b>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <b>Stepney</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <b>Isaac</b>		(Middle) <b>David</b>		(Last) <b>Booth</b>		<b>Dec. 29, 19 55</b>	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>single</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 16, 1898</b>	<b>9. AGE last birthday</b> <b>57</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home construction</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Roanoke Va.,</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William Booth</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Sigmon</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If Yes, give war or dates of service) <b>yes WW I 1 day</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-12-4251</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>William L. Quinn, Aberdeen R.D. 2 Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>approx 1 1/2 yrs.</b>	
<b>IMMEDIATE CAUSE (A)</b> <b>CORONARY OCCLUSION</b>							
<b>ANTECEDENT CAUSE(S) DUE TO</b> <b>Arteriosclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <b>Congenitive C-V. Disease</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> M.</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Dec 1, 19 55, to Dec 29, 19 55, that I last saw the deceased alive on Dec 1, 19 55, and that death occurred at 1 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Alex. Sandecki MD</b>				<b>ADDRESS (Street, city, town, state)</b> <b>BEL AIR, Md</b>			
				<b>DATE SIGNED</b> <b>12.29.1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Jan. 1, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Quinn &amp; Booth</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Ferrum, Franklin Co., Va.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Jan. 2-56</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Nellie G Perry</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Howard K. Mc Comas &amp; Son Abingdon, Md.</b>			

EDWARD A. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12001

## 12024 CERTIFICATE OF DEATH

Reg. Dist. No. 182

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>		LENGTH OF STAY (in this place) <u>R. 5 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill (Rural)</u>			
TOWN <u>Forest Hill MD</u>				TOWN <u>Forest Hill (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LOUISE</u> (Middle) <u>C.</u> (Last) <u>CARCAUD</u>				(Month) <u>Dec</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>July 19-1875</u>	9. AGE last birthday <u>80</u> yrs	IF UNDER 1 Year		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>Thomas Meyers</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Farnberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S ADDRESS <u>Mr H M Boyce</u> <u>14761 Eastern Ave Baltimore MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442x IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>				32 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Hypercholesterolemia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Disease</u>				7			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>				10 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1</u> , 1953, to <u>Dec 8</u> , 1955, that I last saw the deceased alive on <u>Dec 7</u> , 1955, and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill</u>				DATE SIGNED <u>12/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec 12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) <u>Cedar Hill (G.A. Rural)</u> MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Purilla Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster</u>		ADDRESS <u>Baltimore MD</u>	
DATE <u>12-8-55</u>							

REAU V. S.

DEC 12

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 21 Film G191 1-16-56 ems

12002

## CERTIFICATE OF DEATH

12006

Reg. Dist. No. 154

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md.</u>		COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre-de-Grace</u>		<u>20 days</u>		TOWN <u>Port Deposit</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS <u>R. D #1</u>			
3. NAME OF DECEASED (Type or Print) <u>Hester</u> (First) <u>Clark</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>30</u> (Year) <u>1953</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>about 87</u> yrs.	9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Chambers</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>George Clark</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
916.0 IMMEDIATE CAUSE (A) <u>Burns 2+3° 50% Surface</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arterio-sclerotic Cardiac-Vascular Disease</u>							
19a. DATE OF OPERATION <u>12-11-55</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Port Deposit Maryland</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/11/55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Sleeping gown caught fire from stove</u>			
22. I hereby certify that I attended the deceased from <u>12-11</u> , 19 <u>53</u> , to <u>12-30</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>12-30</u> , 19 <u>53</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Bruns</u> M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED <u>12-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-3-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cokesburg</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Debra Patterson</u>		ADDRESS <u>1501 Berryville Rd</u>	
DATE <u>Dec. 31-55</u>							

unknown

unknown

we

13-11 8206 15-30 23

2

Arrival 1-3-435  
Departure 1-3-435  
The bottle was 4000 & 4000  
The bottle was 4000 & 4000

12003

12007

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be **mailed** for use as a burial transit permit.

VS A15C 1-58 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Harre de Grace</u>		<u>11 days</u>		TOWN <u>Harre de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>568 Congress Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Myrtle Coakley</u>				<u>Dec. 1 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Female</u>	<u>W</u>	<u>Widowed</u>	<u>AUG 25, 1968</u>	<u>87</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>House Wife</u>			<u>Home</u>		<u>MD.</u>		<u>U.S.A.</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Nathaniel Gilbert</u>				<u>Josephine Barnaby</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>—</u>		<u>—</u>		<u>Percy Coakley Harre de Grace MD</u>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>420.1 IMMEDIATE CAUSE</u>				<u>Arterio Sclerosis</u>			
<u>ANTECEDENT CAUSE(S) DUE TO</u>				<u>Vascular Disease</u>			
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>				<u>Coronary Atherosclerosis</u>			
<u>STATING UNDERLYING CAUSE LAST, DUE TO</u>				<u>Sudden</u>			
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<u>—</u>				<u>—</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>2D. AUTOPSY?</b>	
<u>—</u>		<u>—</u>		<u>YES <input type="checkbox"/> NO <input type="checkbox"/></u>		<u>YES <input type="checkbox"/> NO <input type="checkbox"/></u>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<u>—</u>		<u>—</u>		<u>—</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21i. HOW DID INJURY OCCUR?</b>			
<u>—</u>		<u>—</u>		<u>—</u>			
<b>22. I hereby certify that I attended the deceased from <u>Nov. 20, 19 55</u>, to <u>Dec. 1, 19 55</u>, that I last saw the deceased alive on <u>Dec. 1, 19 55</u>, and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Charles J. Foley M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Harre de Grace MD</u>			
<b>DATE SIGNED</b> <u>12/1/55</u>							
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>BURIAL</u>		<u>DEC. 3, 1955</u>		<u>ANGEL CEM.</u>		<u>HARREDEGRACE MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Dec. 3-55</u>		<u>G. L. Lewis M.D.</u>		<u>P. Madison Mitchell</u>		<u>HARRE DE GRACE, MD</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 165

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Harford</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Harford</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Havre de Grace</b>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>Belcamp</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Harford Memorial Hospital</b>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <b>David</b>	(Middle) <b>Allen</b>	(Last) <b>Crouse</b>	(Month) <b>12</b> (Day) <b>27</b> (Year) <b>19 55</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>Sept. 20, 1955</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>none</b>	9. AGE last birthday: <b>3</b> yrs. <b>3</b> Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.
11. BIRTHPLACE (State or foreign country): <b>Harford Co., Md.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME: <b>Virgil Crouse</b>		14. MOTHER'S MAIDEN NAME: <b>Irene Curley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <b>none</b>	
17. INFORMANT & ADDRESS: <b>Virgil Crouse, Belcamp, Maryland.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <b>Laryngo-tracheo-bronchitis</b>		
DUE TO		
Antecedent cause(s) (b) <b>DUE TO</b>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <b>Paul J. Mera</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/27/55</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF <b>Dec. 28, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Cokesbury</b>
LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.</b>	24. FUNERAL DIRECTOR <b>Howard K. Mc Comas &amp; Son, Abingdon, Md.,</b>	
DATE REC'D BY LOCAL REG. <b>Dec. 27-55</b>	REGISTRAR'S SIGNATURE <b>Howard K. Mc Comas &amp; Son</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12005  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 133

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Laurel Green</u>	<u>Y.O.H.</u>	TOWN <u>Perryman</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hopt.</u>		STREET ADDRESS (If rural, give location) <u>Rural #1 Aberdeen</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<u>Jacob</u>	<u>Dockman</u>	<u>December 25</u>	<u>1955</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Mar 8th 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>Watchman</u>		<u>Railroad</u>	<u>Pennsylvania</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Wm H Yeekman</u>		<u>Margaret H. Hoopes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
<u>Yes</u> <u>War I.</u>		<u>717-07-5671</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Wm H Yeekman</u>		<u>Margaret H. Hoopes</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Hypertensive Cardiovascular disease</u>	
Antecedent cause(s)	(b) <u>Renal calculus</u>	
Diseases or conditions, if any, giving rise to the above cause	(c) <u>stating underlying cause last</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:
<u>12/28/55</u>		<u>Renal calculus</u>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Ronald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/28/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify):		24. FUNERAL DIRECTOR
<u>Burial</u>		<u>John G. Tarring Aberdeen Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	LOCATION (City, town, or county) (State)
<u>12-29-55</u>	<u>J. G. Tarring</u>	<u>Perryman Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A. D. 1890

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12006

## 12025 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Street Rural</u>				OR TOWN <u>Street Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Martina Jane Gray</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 20 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 16 1897</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Presbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Estella Presbury</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION <u>Wilmington Md.</u>		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hyper tensive Cardiovascular disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/6</u> , 19 <u>53</u> , to <u>12/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>55</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George J. Shansbury</u>				DATE SIGNED <u>12/20/55</u>			
ADDRESS (Street, city, town, state) <u>Revolution St. Havre de Grace Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec 24 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Harford Cemetery</u>		LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
24. REC'D BY REGISTRAR <u>C. K. King</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Basing</u>		ADDRESS <u>Wilmington Md.</u>	
DATE <u>Dec 24 1955</u>							

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12010

## CERTIFICATE OF DEATH

12007

Reg. Dist. No. 180-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u> MARYLAND		CITY OR TOWN <u>Harre-de-Grace</u>		STATE <u>Md</u> COUNTY <u>Hartford</u>		CITY OR TOWN <u>Bel Air</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u>		LENGTH OF STAY (In this place) <u>4 hrs</u>		STREET ADDRESS (If rural give location) <u>RT # 3 Box 200</u>			
3. NAME OF DECEASED (Type or Print) <u>Evelyn Virginia Henderson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 / 13 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>11-5-14</u>	9. AGE last birthday <u>14</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Hendrickson</u>				14. MOTHER'S MAIDEN NAME <u>Francis C. Duncan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
i. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <u>Uremia and acidosis</u>				1 wk.			
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Glomerulonephritis</u>				1 year			
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
ii. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input checked="" type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 13/55</u> to <u>Dec 13/55</u> , that I last saw the deceased alive on <u>Dec 13/55</u> , and that death occurred at <u>4:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howard K. McGonagles</u>				ADDRESS (Street, city, town, state) <u>M.D. 430 N. Union Ave Harre-de-Grace, Md.</u> DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) <u>Emmorton, Harford</u> (State) <u>Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McGonagles &amp; Son, Abingdon, Md.</u>			
DATE <u>Dec. 16-1955</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. All this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-45 (10M)

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12011

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Aberdeen</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>21 Essex Place</u>				STREET ADDRESS (If rural give location) <u>21 Essex Place</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mabel</u> (First) <u>Vaughn</u> (Middle) <u>Hillman</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Dec</u> (Day) <u>24</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Dec 29, 1879</u>		<b>9. AGE last birthday</b> <u>75</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maine</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Silas Bitler</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Francine Dutton</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Earl Stanley Hillman, 21 Essex Place, Aberdeen, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Myocardial failure</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>  </u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>6 Dec</u>, 19<u>55</u>, to <u>19 Dec</u>, 19<u>55</u>, that I last saw the deceased alive on <u>19 Dec</u>, 19<u>55</u>, and that death occurred at <u>12:10 PM</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Earl Stanley Hillman</u>				<b>DATE SIGNED</b> <u>USA Hospital, Aberdeen Pr Gr, Md 27 Dec 55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>DATE THEREOF</b> <u>12/29/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Unity Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Unity, Waldo Co. Maine</u>	
<b>24. REC'D BY REGISTRAR</b> <u>12/29/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mellie K. Terry</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John E. Fanning, Aberdeen, Md</u>			

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. *Asplenium platyneuron* L.

2

12009

12012

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>Harre de Grace</i>		<i>12 yrs.</i>		TOWN <i>Harre de Grace, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Elizabeth Street</i>				STREET ADDRESS (If rural give location) <i>Elizabeth Street</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Carrie M. James</i>				<i>12 - 12 - 19 55</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<i>Female</i>	<i>Negro</i>	<i>Widowed</i>	<i>Feb. 15 1898</i>	<i>57</i> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<i>Housewife</i>					<i>Rosehill, N. C.</i>		<i>U. S. A.</i>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>Unknown</i>				<i>Senny Powers</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S ADDRESS</b>			
				<i>Elizabeth Street</i> <i>Mr. Jet James - Harre de Grace, Md.</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<i>Coronary Thrombosis</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <i>Hypertensive - Arteriosclerotic Heart Disease</i>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b>	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>2/21</i>, 19 <i>51</i>, to <i>12/11</i>, 19 <i>55</i>, that I last saw the deceased alive on <i>12/11</i>, 19 <i>55</i>, and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<i>George T. Stansbury</i>				<i>M.D. 569 Revolution St. Harre de Grace, Md.</i>		<i>12/12/55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<i>Removal</i>		<i>12-14-55</i>		<i>Halls Cemetery</i>		<i>Rosehill, N. C.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>DEC 14-55</i>		<i>A. L. Lewis M.D.</i>		<i>Otelis J. Bullock - Harre de Grace, Md.</i>			

1942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12013				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				12010 Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								No. ....			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:							
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>					
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bell Air</u>				LENGTH OF STAY (in this place) <u>36</u>				CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Bell Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>111 No. Bond St.</u>				STREET ADDRESS (If rural, give location) <u>111 No Bond St</u>							
3. NAME OF DECEASED: (Type or Print) <u>GEORGE ROBERT JONES</u>				4. DATE OF DEATH <u>DEC 11 19 55</u>							
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>Col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married Nov. 23 1888</u>		8. DATE OF BIRTH: <u>67</u>		9. AGE last birthday: <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Hardy man</u>				10b. KIND OF BUSINESS OR INDUSTRY:				11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOHN JONES</u>				14. MOTHER'S M maiden NAME: <u>SALLY JAMES</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>214-34-4030</u>				17. INFORMANT & ADDRESS: <u>Wife - Mary Jones, Bell Air, Md.</u>			
18. MEDICAL CERTIFICATION										INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:											
Immediate cause (a) <u>Suffocation of Pulmonary Edema</u>										<u>2 days</u>	
Antecedent cause(s) (b) <u>Congestive Heart Failure</u>										<u>10 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause (c) <u>stating underlying cause last</u>											
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY				21c. (City or town), (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
SIGNATURE <u>Philip W. Neuman</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Dec 12, 1955</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>Dec 14/55</u>				NAME OF CEMETERY OR CREMATORY <u>Twin Methodist</u>			
DATE REC'D BY LOCAL REG. <u>12-13-55</u>				REGISTRAR'S SIGNATURE <u>Freddie Townsend</u>				24. FUNERAL DIRECTOR <u>Joe J. Tait</u>			
								LOCATION (City, town, or county) <u>Bell Air Md</u>			
								ADDRESS			

RECEIVED  
JAN 14 1955  
U. S. BUREAU OF INVESTIGATION

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 515C 1-55 104

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12014 CERTIFICATE OF DEATH

12011

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		LENGTH OF STAY (In this place) <u>2 hrs. 5 Min.</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> ( <u>Belcamp</u> )			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				STREET ADDRESS (If rural give location) <u>Box 137A Route - 2</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Baby John Bay Samuel Kludy</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 23</u> 19 <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec. 23, 1955</u>	9. AGE last Birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. <u>2</u> <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kludy</u>				14. MOTHER'S MAIDEN NAME <u>Cecilia Rochester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>John Kludy, Bel Air R.D. #2 Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
I. IMMEDIATE CAUSE (A) <u>Congenital Absence left diaphragm with rudimentary lung formation.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 5 min</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u></u>							
(C) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/23</u> , 19 <u>55</u> , to <u>12/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>55</u> , and that death occurred at <u>7:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Frederick J. Johnson</u> M.D.				ADDRESS (Street, city, town, state) <u>1724 W. 13th St. Belcamp Md.</u>		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		LOCATION (City, town, or county) (State) <u>Abingdon, Harford Md.</u>	
24. REC'D BY REGISTRAR <u>U.S.C. 27-1955-G.L. Lewis M.D.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas &amp; Son, Abingdon, Md.</u>			

RECEIVED

DEC 22 1966

BUREAU

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

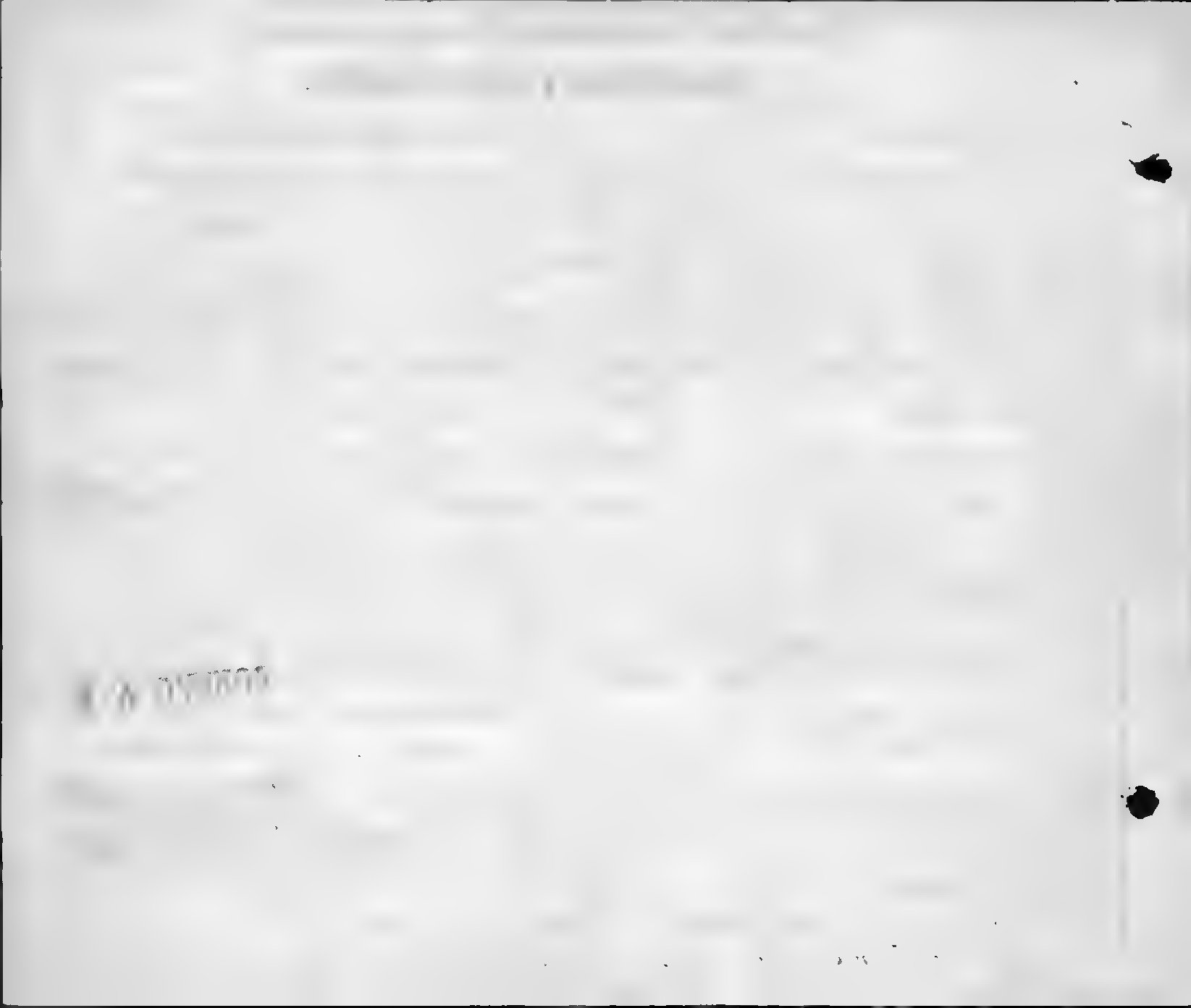
12013

12026

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Pennsylvania</i> COUNTY <i>7.ampton Co.</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Edgewood</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hazareth</i>		751..	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>APT 3A. Harford Manor</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Lubina Catherine Metz</i>				<i>Dec 1st 1955</i>			
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>white</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>widowed</i>	<b>8. DATE OF BIRTH</b> <i>Oct 20th 1867</i>	<b>9. AGE last birthday</b> <i>88</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life; even if retired) <i>Housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Home</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Pennsylvania</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>Jacob Young</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Catherine Bauer</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>none</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mrs Victor Albrecht Edgewood Md.</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>332x IMMEDIATE CAUSE (A)</b> <i>Cerebral thrombosis</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>no 23 55</i>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>myocarditis with auricular fibrillation</i>						<i>some years</i>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Nov 10, 1955, to Dec 1, 1955, that I last saw the deceased alive on Nov 30, 1955, and that death occurred at 8 A. M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>John O. Hodous</i>		<b>M.D.</b>		<b>ADDRESS (Street, city, town, state)</b> <i>Edgewood Md</i>		<b>DATE SIGNED</b> <i>12-1-55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>Dec 5th 1955</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Greenwood Cemetery</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Hazareth, Penna.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Norma G. Moore</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John F. Harbinger</i>		<b>ADDRESS</b>	
<b>DATE</b> <i>Dec 5, 1955</i>							



## 12027 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Park Royal</u>		<u>36 yrs.</u>		TOWN <u>Koppa Md</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>---</u>				STREET ADDRESS (If rural give location) <u>---</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Smith</u> (Middle) <u>Levering</u> (Last) <u>Moore</u>				(Month) <u>Dec.</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. CO. OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 10, 1920</u>	9. AGE last birthday <u>85</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Computer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Elmer B. Moore</u>				14. MOTHER'S MAIDEN NAME <u>---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hebert M. Moore, 1011 E. 1st St</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
171X IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma Prostate</u>				<u>2 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>---</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>---</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 6, 1955</u> , to <u>Dec. 7, 1955</u> , that I last saw the deceased alive on <u>Dec. 6, 1955</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city, town, state) <u>Kingsville, Md.</u>		DATE SIGNED <u>Dec. 7 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		LOCATION (City, town, or county) (State) <u>Harford Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Townsend</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cutler</u>		ADDRESS <u>Forke Md</u>	
DATE <u>12-9-55</u>							

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12015  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12015  
Reg. Dist.

No. 185-

1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Georgia</u> COUNTY <u>Jeff Davis</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Hazlehurst</u> 47X-2 STREET ADDRESS (If rural, give location) ADDRESS —							
3. NAME OF DECEASED: (Type or Print) <u>Nathan L Murray Jr.</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>December 26</u> 19 <u>55</u> (Month) (Day) (Year)							
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>4/6/1931</u>		9. AGE last birthday: <u>24</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Labour</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>		11. BIRTHPLACE (State or foreign country): <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Nathan L. Murray Sr.</u>						14. MOTHER'S MAIDEN NAME: <u>Temple Dickins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY No: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Nancy W. Murray, Harford House, Md.</u>					
18. MEDICAL CERTIFICATION											
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Punch Wound Cerebrum</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause stating underlying cause last</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION: <u>12/26/55</u>				19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>				21c. (City or town) (County) (State) <u>Harford House Harford Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12/26/55 7:30 P.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				21f. HOW DID INJURY OCCUR? <u>Shot self</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
SIGNATURE <u>Dorold C Palmer</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/26/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>				DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hazlehurst</u>				LOCATION (City, town, or county) (State) <u>Hazlehurst, Ga.</u>	
DATE REC'D BY LOCAL REG. <u>DEC. 27-1955</u>				REGISTRAR'S SIGNATURE <u>U. L. Smith M.D.</u>				24. FUNERAL DIRECTOR <u>James H. Smith, Md.</u> ADDRESS			

Age Group	2003	2004	2005
18-29	~85	~88	~90
30-49	~75	~78	~80
50-69	~65	~68	~70
70+	~55	~58	~60

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2000

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12016

## 12016 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVER DE GRACE</u> LENGTH OF STAY (In this place) <u>19 hrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Mem. Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen</u> 31 STREET ADDRESS (If rural give location) <u>41 Liberty ST</u> 1			
3. NAME OF DECEASED (Type or Print) (First) <u>Lucy</u> (Middle) <u>Pease</u> (Last) <u>NORMAN</u>			4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>6</u> (Year) <u>1955</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>5 March 1889</u>	9. AGE (last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXXXXXXXX</u>	11. BIRTHPLACE (State or foreign country) <u>Framstown W Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>(deceased) Andrew Jackson</u>			14. MOTHER'S MAIDEN NAME <u>(deceased) Mary Jones</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>————</u>	17. INFORMANT & ADDRESS <u>41 Liberty St. Letcher Norman. Aberdeen, Md.</u>				
18. MEDICAL CERTIFICATION DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arterio-Sclerotic Cardiovascular Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>8-10 yrs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		
19. DATE OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>December 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/6</u> , 19 <u>55</u> , and that death occurred at <u>10 10</u> M., from the causes and on the date stated above. SIGNATURE <u>Frederick J. Tarrington</u> ADDRESS (Street, city, town, state) <u>M.D. 17 N. Phila. Bld. Parkersburg, Md.</u> DATE SIGNED <u>12/6/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>	DATE THEREOF <u>12/7/55</u>	NAME OF CEMETERY OR CREMATORY <u>James Cemetery</u>		LOCATION (City, town, or county) <u>Framtown, W. Va.</u>			
24. REC'D BY REGISTRAR <u>Dec. 8-1955</u>	REGISTRAR'S SIGNATURE <u>W. J. Lewis M. M.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarrington</u>		ADDRESS <u>Aberdeen, Md.</u>			

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RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12017

12028

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

## 1. PLACE OF DEATH

COUNTY Harford

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Abingdon

LENGTH OF STAY (In this place)

35 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Abingdon

STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED (Type or-Print)

(First)

(Middle)

(Last)

ViolaS.Norton

4. DATE OF DEATH (Month) (Day) (Year)

Dec. 2119 55

5. SEX

Female

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

married

8. DATE OF BIRTH

May, 20, 1896

9. AGE last birthday

59 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Servant

10b. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Hollingsworth

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT &amp; ADDRESS

Harold Norton Abingdon, Maryland

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4. IMMEDIATE CAUSE (A)

Cerebral Vascular Accident

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

Hypertensive Cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED White ☐ Not white ☐ M. ☐ et work ☐ et work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/18, 19 55, to 12/26, 19 55, that I last saw the deceased alive on 12/26, 19 55, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

Dec. 25, 1955

NAME OF CEMETERY OR CREMATORY

John Wesley

LOCATION (City, town, or county)

Abingdon, Harford, Md.

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

Dec 27, 1955 Norma E. MooreHoward K. McGee & Son, Abingdon, Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

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RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12017 CERTIFICATE OF DEATH

12018

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>				STATE <u>MARYLAND</u> COUNTY <u>CECIL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>HAURE DE GRAVE</u>		<u>1 1/2 DAYS</u>		TOWN <u>PORT DEPOSIT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ELIZABETH</u> (First) <u>PIERCE</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>DECEMBER</u> (Day) <u>27</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>SEPT. 8, 1884</u>	<b>9. AGE last birthday</b> <u>67</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
				Months		Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Counselor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>NEW JERSEY</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no; or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>PORT DEPOSIT</u> <u>LOTT PIERCE</u> <u>MD</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<u>48 hrs</u>	
<b>IMMEDIATE CAUSE (A)</b> <u>Peritonitis</u>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Perforated Cancer of cecum (?)</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>of ovary (?)</u>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>27</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>December 19, 1955</u> , <b>to</b> <u>Dec 27, 1955</u> , <b>that I last saw the deceased alive on</b> <u>Dec 27, 1955</u> , <b>and that death occurred at</b> <u>6:00 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Wm. K. Breuder</u> <b>M.D.</b>						<b>ADDRESS</b> (Street, city, town, state) <b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Dec 30/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Brookview Cem</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Rising Sun, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b> <u>Dec 29-55</u>		<u>W. A. Lewis M.D.</u>		<u>E. E. Tyson</u>		<u>Rising Sun, Md.</u>	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12039 **CERTIFICATE OF DEATH**

12019

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural, Fallston</u>		<u>44 years</u>		TOWN <u>Rural, Fallston</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Sarah Jane Preston</u>				<u>12 29 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED.</b> (Specify)	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS</b>
<u>female</u>	<u>W</u>	<u>Widowed</u>	<u>May 12, 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>House wife</u>					<u>Harford Md.</u>		
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Amblerman</u>				<u>Elizabeth Phillips</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		
<u>No</u>					<u>Mrs Edw. Keller 4507 Bacon Rd Balto. Md</u>		
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Acute coronary thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B) <u>Chronic hypertensive cardio-vascular disease.</u>		<u>??</u>	
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE</b> (Home, farm, factory, of injury street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>April 4</u>, 19<u>53</u>, to <u>Dec. 29</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/27/55</u>, 19<u>55</u>, and that death occurred at <u>3:00 AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Willard P. Hudson, M.D.</u>				<u>Forest Hill, Md.</u>		<u>12-30-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>	<b>DATE THEREOF</b>	<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)			
<u>BURIAL</u>	<u>12-31-55</u>	<u>Harford Md.</u>		<u>Harford Md.</u>			
<b>24. REC'D BY REGISTRAR</b>	<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>		
<u>1-3-56</u>	<u>Willard P. Hudson</u>		<u>Willard P. Hudson</u>		<u>Harford Md.</u>		

RECEIVED  
JAN 5 1956  
BUREAU OF

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

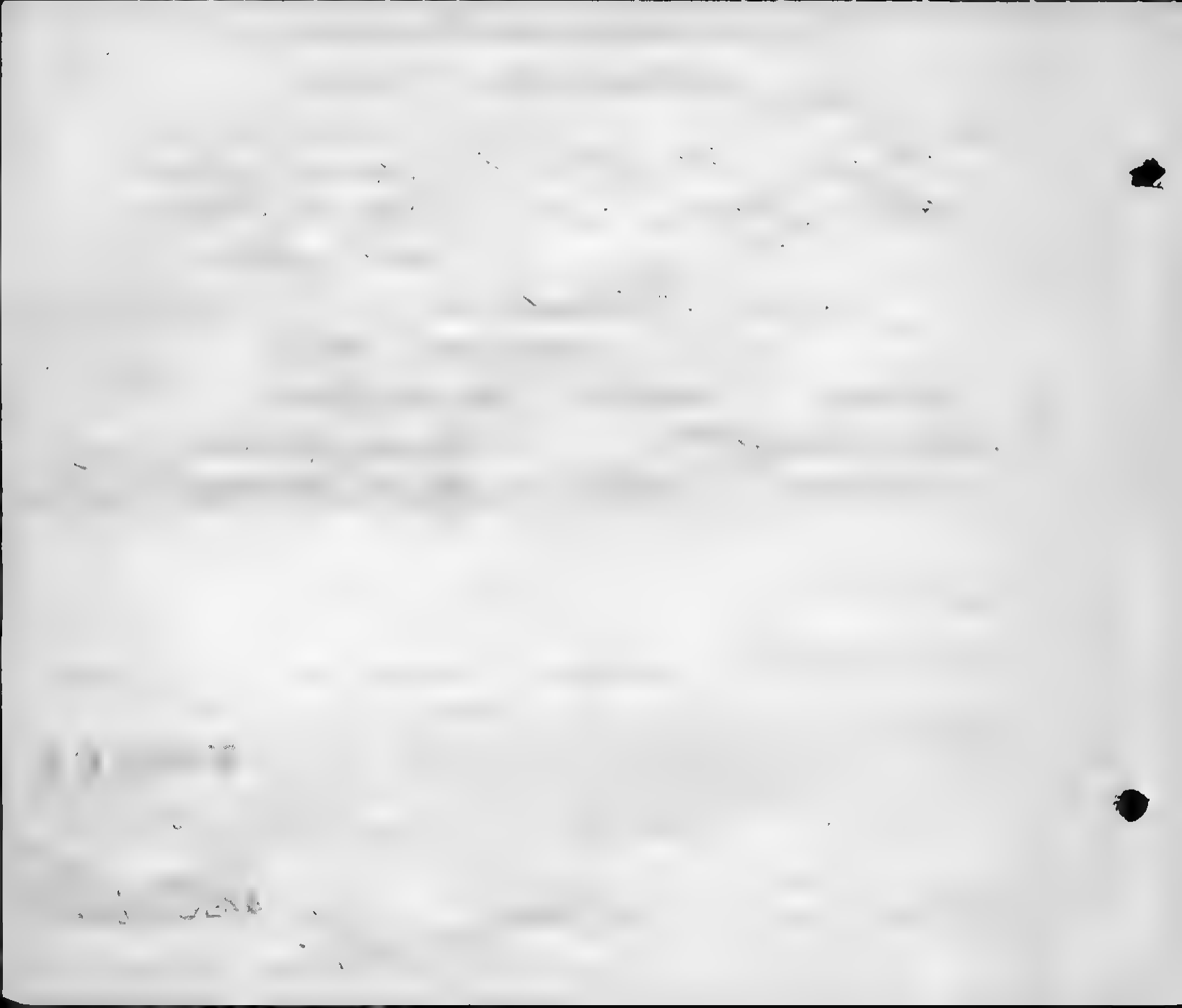
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12020

12018 **CERTIFICATE OF DEATH**

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		STATE <i>MARYLAND</i>		COUNTY <i>Harford</i>		STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
TOWN <i>Harford Chase</i>		<i>10 yrs.</i>		TOWN <i>Harford Chase</i>		<i>10 yrs.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>213 N. Stokes</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>Geese</i> (Middle) <i>Richardson</i> (Last) <i>Richardson</i>				(Month) <i>12</i> (Day) <i>15</i> (Year) <i>1955</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>10. IF UNDER A YEAR</b>		
<i>Male</i>	<i>White</i>	<i>Widowed</i>	<i>Unknown</i>	<i>abt 70</i> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>Unknown</i>		<i>Unknown</i>		<i>Harford Chase</i>		<i>U.S.A.</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>Robert Richardson</i>				<i>Frances Sheridan</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<i>Unknown</i>		<i>Unknown</i>		<i>Francis Richardson</i> <i>213 N. Stokes</i>			
<b>18. MEDICAL CERTIFICATION</b>				<b>19. INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>1. IMMEDIATE CAUSE (A)</b>				<i>Cervix, Pelvic Cancer</i>			
<b>2. ANTECEDENT CAUSE(S) DUE TO</b>				<i>Essential Hypertension Disease</i>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>				<i>Essential Hypertension</i>			
<b>3. UNDERLYING CAUSE LAST. DUE TO</b>				<i>8 hrs</i>			
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 12/17/55 to 12/15/55, that I last saw the deceased alive on 12/15/55, and that death occurred at 1 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<i>Francis J. Fagan M.D.</i>				<i>440 P. Morris Ave</i>		<i>Nov 13/16/55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b> <b>(State)</b>	
<i>Burial</i>		<i>12/17/55</i>		<i>St. James</i>		<i>Harford Chase Md.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>DATE: Dec. 16-1955</i>		<i>G. L. Lewis M.D.</i>		<i>Livingston</i>		<i>Harford Chase Md.</i>	



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12021

12030

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u>				2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walters Nursing Home</u>				STREET ADDRESS (If rural give location) <u>823 Juniata</u>			
3. NAME OF DECEASED (Type or Print) <u>BERNARD</u> <u>RUFFINI</u>				4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>10/21/1884</u>	9. AGE last birthday <u>71</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harbor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harbor</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Dominick Ruffini</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Mary F. Ruffini, Harford, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						<u>30 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Hypertensive Cardio-vascular Disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>  </u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 2, 1955</u> to <u>Dec. 28, 1955</u> , that I last saw the deceased alive on <u>Dec. 26, 1955</u> , and that death occurred at <u>5:30 P.M.</u> on the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D. Forest Hill, Md.				ADDRESS (Street, city, town, state) <u>Harford, Md.</u>			
DATE SIGNED <u>12-28-55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Air</u>		LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>1-3-56</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Priscilla Lowwood</u> ADDRESS <u>Harford, Md.</u>			

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S. 415A-5-53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supplied by the Bureau of Prisons. The correct age is especially important. Physicians: please write clearly and legibly.

(X)

12019  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 12022-  
No. 12022-

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>HARFORD</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>32 BELAIR</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>on</b>		STREET ADDRESS (If rural, give location) <b>7820 Aiken Avenue #14</b>	
3. NAME OF DECEASED: (Type or Print) <b>Melvin E. SCHNORR</b>		4. DATE OF DEATH (Month) <b>12</b> (Day) <b>9</b> (Year) <b>= 55</b>	
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>	8. DATE OF BIRTH: <b>Aug. 20, 1919</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Auto Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Edward Motors</b>	9. AGE last birthday: <b>36</b> yrs.
11. BIRTHPLACE (State or foreign country): <b>Rochester, Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Earl Schnorr</b>		14. MOTHER'S MAIDEN NAME: <b>Ethel Fleener</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>Yes</b> (If Yes, give war or dates of service) <b>2</b>		16. SOCIAL SECURITY No.: <b>477-07-7681</b>	
17. INFORMANT & ADDRESS: <b>Mrs. Ruth N. Schnorr, 7820 Aiken Ave. #14</b>			

18. MEDICAL CERTIFICATION

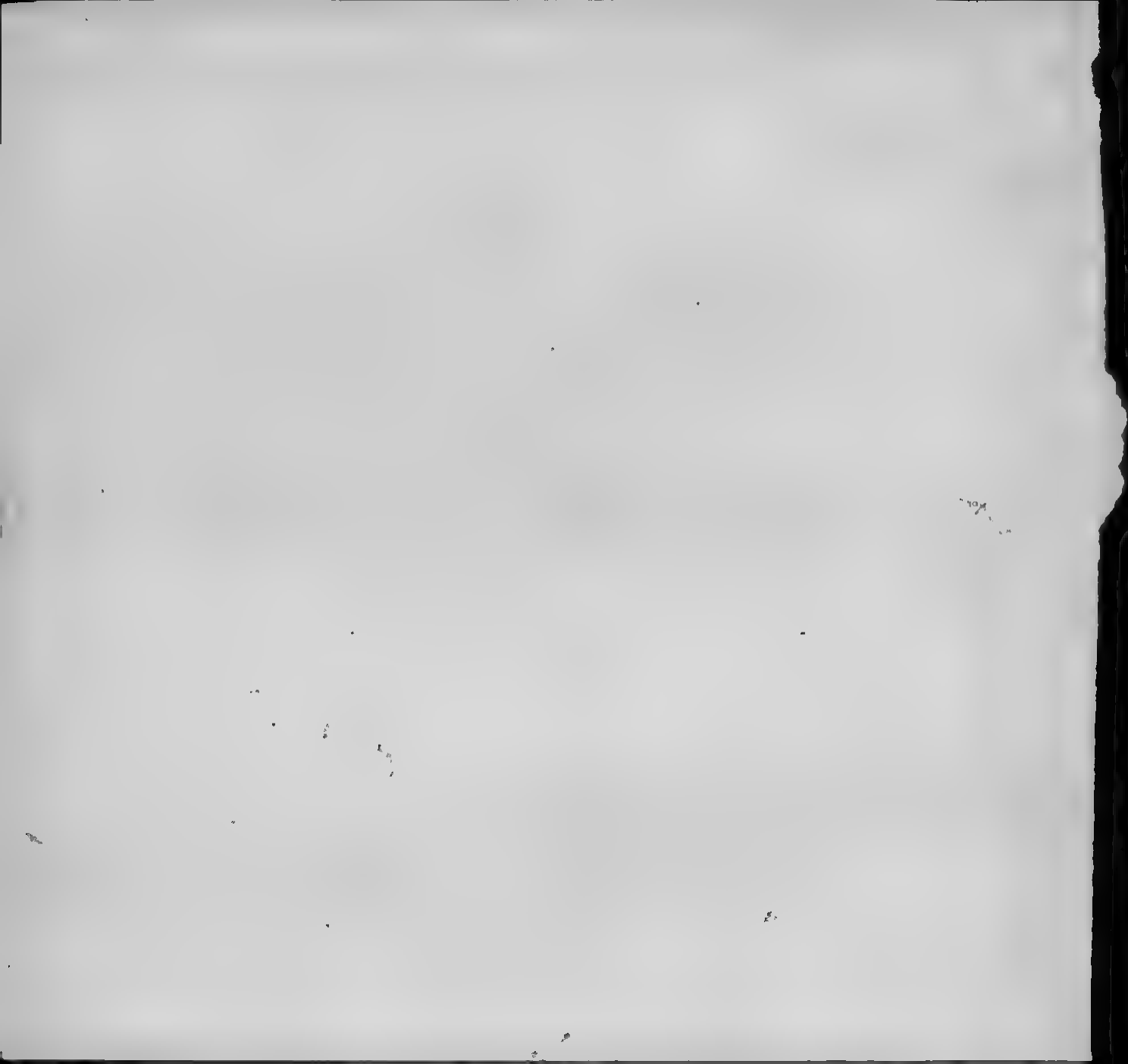
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
<b>42-1</b> <b>Immediate cause</b> (a) <b>Coronary Sclerosis</b> DUE TO <b>Antecedent cause(s)</b> (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE <b>R. F. Fisher</b>	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
DATE SIGNED <b>12-9-55</b>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF: <b>Dec. 11, 1955</b>	NAME OF CEMETERY OR CREMATORY: <b>Rochester, Minnesota</b>	
DATE REC'D BY LOCAL REG. <b>Dec 13 1955</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	24. FUNERAL DIRECTOR ADDRESS: <b>Leonard J. Ruck, 5305 Harford Road</b>	

Write the causes of

82



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12023

12031

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>HARFORD</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>RURAL WHITE HALL</u>		TOWN <u>RURAL WHITE HALL R.I.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>RUSSELL</u> (Middle) <u>CHARLES</u> (Last) <u>SEITZ</u>		(Month) <u>12</u> (Day) <u>30</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
			<u>2-22-1893</u>
9. AGE last birthday <u>62</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	<u>FIREMAN</u>	<u>HARFORD Co., Md.</u>	<u>U.S.A.</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>CHARLES SEITZ</u>		<u>ANNA ORWIG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, - (ink).) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>183-18-7927</u>	
17. INFORMANT & ADDRESS			
<u>Mrs. Ella Seitz, White Hall Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
4. IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Sclerosis</u>		<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. at work) (Not while at work)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>53</u> , to <u>Dec 30</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>53</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul D. Shaul</u>		DATE SIGNED <u>12-31-55</u>	
M.D. <u>Shrewsbury Pa</u>		ADDRESS (Street, city, town, state)	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR	
<u>Burial</u>		<u>Priscilla Lowwood</u>	
DATE THEREOF <u>1-2-56</u>		REGISTRAR'S SIGNATURE	
NAME OF CEMETERY OR CREMATORY <u>OLD HOPEWELL</u>		25. FUNERAL DIRECTOR'S SIGNATURE	
LOCATION (City, town, or county) <u>HOPEWELL TWP. YORK Co., Pa.</u>		<u>Kenneth Oshman Stewart</u>	
24. DATE <u>1-3-56</u>		ADDRESS	

BUREAU V. S.

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RECEIVED

12024

12032

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## INSTRUCTIONS

The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Harford</u>
CITY OR TOWN <u>Harrington</u>	LENGTH OF STAY (in this place)	CITY OR TOWN <u>Harrington</u>	STREET ADDRESS (in rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
<u>Samuel S. Snower</u>		<u>Dec 11</u> 19 <u>55</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>Oct 15, 1869</u>
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>9. AGE last birthday</b> Yrs. <u>86</u>
<u>Farmer</u>		<u>Harford Co, Md</u>	<b>11. BIRTH PLACE (State or foreign country)</b>
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
<u>Lessie Snower</u>		<u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT'S ADDRESS</b>
<u>No</u>		<u>No</u>	<u>Mrs. Harriet Snower</u>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>4. IMMEDIATE CAUSE (A)</b>		<u>Thrombosis</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>		<u>Generalized Arteriosclerosis</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>		<u>old age</u>	
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
		<u>1 wk</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>	
<input type="checkbox"/>		<u>Harrington, Md</u>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. HOW DID INJURY OCCUR?</b>	
<u>Dec 10</u> <u>55</u>		<u>While at work</u>	
<b>22. I hereby certify that I attended the deceased from <u>Jan 1</u> 19 <u>53</u>, to <u>Dec 11</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>Dec 10</u>, 19 <u>55</u>, and that death occurred at <u>6:45</u> M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b>		<b>DATE SIGNED</b>	
<u>Harriet Snower</u> M.D.		<u>Dec 12, 1955</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>	<b>DATE THEREOF</b>	<b>NAME OF CEMETERY OR CREMATORY</b>	<b>LOCATION (City, town, or county) (State)</b>
<u>Burial</u>	<u>Dec 14, 1955</u>	<u>Harford Co, Md</u>	<u>Harford Co, Md</u>
<b>24. REC'D BY REGISTRAR</b>	<b>REGISTRAR'S SIGNATURE</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	<b>ADDRESS</b>
<u>Dec 15, 1955</u>	<u>Cornelia W. Kirk</u>	<u>Ad Bailey</u>	<u>Harrington, Md</u>

312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12033 . . .  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12025  
 Reg. Dist. 180  
 No. 180

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Edgewood</b>		LENGTH OF STAY (in this place) <b>14 yrs.</b>		CITY (If outside corporate limits write RURAL and give nearest town) <b>Edgewood</b>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <b>Marvin M. Stokley</b>				4. DATE OF DEATH <b>December 10 1955</b>			
5. SEX: <b>male</b>		6. COLOR OR RACE: <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>		8. DATE OF BIRTH: <b>8-5-77</b>	
9. AGE last birthday: <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Mechanic</b>		11. BIRTHPLACE (State or foreign country): <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Charles L. Stokley</b>				14. MOTHER'S MAIDEN NAME: <b>Susan C. Brothers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of) <b>yes Spanish American</b>				16. SOCIAL SECURITY No.: <b>Wash., D.C.</b>			
17. INFORMANT & ADDRESS: <b>Marion A. Stokley, 4803-7th St., N.E., Wash., D.C.</b>							

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <b>Carcinoma tongue with metastases to lungs</b> DUE TO Antecedent cause(s) (b) <b>Arteriosclerotic C<sup>v</sup> Disease</b> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
19. DATE OF OPERATION: <b>April 1, 1955</b> 19b. MAJOR FINDING OF OPERATION: <b>carcinoma tongue Radon implanted</b>					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>Gerald C Palmer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/12/11/55</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>Dec. 14, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
LOCATION (City, town, or county) (State) <b>Arlington, Fairfax, Va.</b>					
DATE REC'D BY LOCAL REG. <b>Dec 14, 1955</b>		REGISTRAR'S SIGNATURE <b>Norma B. Moore</b>		24. FUNERAL DIRECTOR ADDRESS <b>W.W. Chambers, Riverdale, Maryland.</b>	



## 12034 CERTIFICATE OF DEATH

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Aberdeen</u>				OR TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Stephenay Road</u> <u>Aberdeen, Md</u>		STREET ADDRESS (If rural give location)		<u>RD #1, Stephenay Road</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>POLLY</u> <u>ANNIE</u> <u>SWICK</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec</u> <u>31</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 25, 1955</u>	9. AGE last birthday yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 24 HRS. Days <u>6</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Robert Swick</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Jean Rowsor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Richard R Swick</u> <u>Stephenay Road, Aberdeen, Md</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cardiac dilatation</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary edema</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 8:40 AM</u> , to <u>Dec 31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u></u> , 19 <u></u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
SIGNATURE <u>Richard R Swick</u>				ADDRESS (Street, city, town, state) <u>M.D. US Army Hospital Aberdeen Pr'r, Md</u>		DATE SIGNED <u>2 Jan 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>removed</u>		DATE THEREOF <u>1/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Bennshoff Cemetery</u>		LOCATION (City, town, or county) (State) <u>Johnstown, Pa</u>	
24. REC'D BY REGISTRAR DATE <u>Jan. 3-1956</u>		REGISTRAR'S SIGNATURE <u>Nellie G Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Yarning</u>		ADDRESS <u>Aberdeen Md.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

STANDARD V. S.

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## 12035 CERTIFICATE OF DEATH

Reg. Dist. No. 18.1

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Harrods Grace</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harrods Grace</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box #93 Rural #1</u>				STREET ADDRESS (If rural give location) <u>Box #93 Rural #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Andrew</u> (Middle) <u>E.</u> (Last) <u>Thomas</u>				(Month) <u>12</u> (Day) <u>12</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 17th 1877</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self emp. farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		Months		Days
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		Hours		Min.
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-32-8978</u>		17. INFORMANT & ADDRESS <u>Herman H. Thomas Harrods Grace #1 Md.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
I. IMMEDIATE CAUSE (A) <u>47 yr</u>				INTERVAL BETWEEN ONSET AND DEATH			
II. ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Arteriosclerosis</u>							
III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Coronary Atherosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 11, 1955</u> to <u>Dec 12, 1955</u> , that I last saw the deceased alive on <u>Dec 11, 1955</u> , and that death occurred at <u>9:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William J. Perry</u> M.D.				ADDRESS (Street, city, town, state) <u>Harrods Grace, Md.</u>		DATE SIGNED <u>Dec 14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12/15/55</u>	NAME OF CEMETERY OR CREMATORY <u>Angle Hill Cemetery</u>		LOCATION (City, town, or county) <u>Harrods Grace, Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>Dec 13-55</u>	REGISTRAR'S SIGNATURE <u>Willie R. Perry</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barry</u>		ADDRESS <u>Abertown, Md.</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U. S. A.

1955

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12036

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

12028

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Harford</i>	
CITY OR TOWN <i>Belt Air</i>		LENGTH OF STAY (In this place)		CITY OR TOWN <i>Belt Air</i>		CITY OR TOWN <i>Belt Air</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Bel Air Nursing Home</i>				STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Oscar Thompson</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>December-9-55</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov 18, 1870</i>	9. AGE last birthday <i>85</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Self-employed</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
11. FATHER'S NAME <i>H. M. Thompson</i>				14. MOTHER'S MAIDEN NAME <i>Anna E. Huff</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT & ADDRESS <i>Ray G. Gwalt</i>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
X IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <i>12/9</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/7</i> , 19 <i>55</i> , to <i>12/9</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/7</i> , 19 <i>55</i> , and that death occurred at <i>6A</i> M., from the causes and on the date stated above.							
SIGNATURE <i>Lerald E. Palmer</i> M.D.				ADDRESS (Street, city, town, state) <i>Belt Air Md.</i>		DATE SIGNED <i>12/9/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>Dec 12 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Belt Air</i>		LOCATION (City, town, or county) (State) <i>Harford Co. Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Corneilia W. Kirk</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H. E. Gwalt</i>		ADDRESS	
DATE <i>Dec. 15, 1955</i>							

3-1-1008

1.7.1.1.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12037

CERTIFICATE OF DEATH

Reg. Dist. No. 12020

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>HARFORD</b>	MARYLAND	STATE <b>PA.</b>	COUNTY <b>YORK</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CARRIFF</b>	LENGTH OF STAY (in this place) <b>2 DAYS</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>RURAL - DELTA</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <b>R.D. #2</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>WILLIAM</b>	(Middle) <b>JAMES</b>	(Last) <b>UREY</b>	(Month) <b>DEC</b> (Day) <b>12</b> (Year) <b>1955</b>
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>WIDOWED</b>	8. DATE OF BIRTH: <b>MAR. 25, 1883</b>
9. AGE last birthday: <b>72</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>WOODWORK</b>	
11. BIRTHPLACE (State or foreign country): <b>CHESTER, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>GEORGE UREY</b>		14. MOTHER'S MAIDEN NAME: <b>MARGARET BLACKBURN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>CURTIS UREY, DALLASTOWN, PA.</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE: <b>Coronary occlusion</b>		<b>6 1/2 hours</b>	
(B) ANTECEDENT CAUSE (S): <b>Coronary sclerosis</b>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>12/10</b> , 19 <b>55</b> to <b>12/12</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>12/10</b> , 19 <b>55</b> , and that death occurred at <b>9:30 A</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Benj. J. J. J.</b>		DATE SIGNED <b>12/13/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>12-15-55</b>	
NAME OF CEMETERY OR CREMATORY <b>AIRVILLE</b>		LOCATION (City, town, or county) (State) <b>AIRVILLE, PA.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>12.14.55</b>		REGISTRAR'S SIGNATURE <b>Muriel Lowrod</b>	
24. FUNERAL DIRECTOR <b>JOHN H. HARKINS, DELTA, PA.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEAD

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12038 CERTIFICATE OF DEATH

12031

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>RURAL WHITE HALL</u>				TOWN <u>RURAL WHITE HALL</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>J.</u> (Middle) <u>NELSON</u> (Last) <u>WILEY</u>				(Month) <u>12</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>7-4-1860</u>	9. AGE last birthday <u>95</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>HARFORD CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>DAVID WILEY</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN WILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Samuel Wile, Whitehall Rd.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Chronic myocarditis.</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General arteriosclerosis of old age.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 15, 1955</u> , to <u>Dec 30, 1955</u> , that I last saw the deceased alive on <u>Dec. 29, 1955</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Norman H. Gemmill</u>				DATE SIGNED <u>Dec. 30, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>1-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>NORRISVILLE</u>	
24. REC'D BY REGISTRAR <u>Bessie Howard</u>				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Chubb</u>	
DATE <u>1-3-56</u>				ADDRESS <u>Stewartstown Pa.</u>		LOCATION (City, town, or county) <u>NORRISVILLE, HARFORD CO., MD.</u>	

1951

MASSACHUSETTS DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH

# 1951 CERTIFICATE OF DEATH

ATTEST: I, \_\_\_\_\_, Registrar of Vital Records, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health.

MASSACHUSETTS DEPARTMENT OF HEALTH  
BOSTON, MASS.

RECEIVED

BUREAU V. E.

JAN 5 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 12039 CERTIFICATE OF DEATH

12030

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i> <i>Maryland</i> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Frederick</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS				STATE <i>Maryland</i> COUNTY <i>Harford</i> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Frederick</i> STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <i>Noah Isaac Wimmer</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>12/12/55</i>			
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>White</i>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATE</b> <i>Married</i>		<b>8. DATE OF BIRTH</b> <i>Dec. 17 1878</i>	
<b>9. AGE last birthday</b> <i>76</i> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Capitol Hill Va.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>Harvey Wimmer</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Eliza Wilson</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) (If Yes, give war or dates of service) <i>Unknown</i>				<b>16. SOCIAL SECURITY NO.</b> <i>Unknown</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Frank Wimmer</i> <i>Frederick Md.</i>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>II. MEDICAL CERTIFICATION</b>			
<b>1. IMMEDIATE CAUSE (A)</b> <i>420.0</i>				<b>1. PULMONARY EDEMA</b>			
<b>2. ANTECEDENT CAUSE(S) DUE TO</b>				<b>2. HEART FAILURE</b>			
<b>3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) DUE TO (C)				<b>3. ARTERIOSCLEROTIC HEART DISEASE</b>			
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 hour</i> <i>1 hour</i> <i>2 yr.</i>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>12-12-55</i>, to <i>12-12-55</i>, that I last saw the deceased alive on <i>12-12-55</i>, and that death occurred at <i>4:50 P.M.</i> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Robert R. Perry</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Frederick, Md.</i>		<b>DATE SIGNED</b> <i>12-14-55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>Burial</i>		<i>12/15/55</i>		<i>Episcopal</i>		<i>Perryman Md.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>Dec 15-55</i>		<i>Mellie R. Perry</i>		<i>Robert R. Perry</i>		<i>Frederick Md.</i>	

1903 CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1903

RECEIVED